

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1-11, File #233 9-11-58 et

09158

9169

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY KENT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENNEDYVILLE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY KENT	
c. LENGTH OF STAY IN 1b 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN RD 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Groves Nursing Home		d. STREET ADDRESS FAIRLEE	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MOLLIE		First AUGUSTA	Middle ACKERMAN
Last FAIRLEE		4. DATE OF DEATH AUG 25	Month Day Year 1958
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 30, 1877
9. AGE (In years last birthday) yrs. 80		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MANISTEE, MICHIGAN		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME CRR PERGANDE		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT MABEL ATKINSON		Address CHESTERTOWN, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY OEDEMA DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO 8 years		INTERVAL BETWEEN ONSET AND DEATH 6 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PNEUMONIA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 25, 1958 to Aug 25, 1958 that I last saw the deceased alive on Aug 25, 1958 , and that death occurred at 7:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Worton		DATE SIGNED	
ACTUAL SIGNATURE Florence Pergande Joyce		M.D.	
PHYSICIAN'S NAME (Type) FLORENCE PERGANDE JOYCE		11	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 28/58	22c. NAME OF CEMETERY OR CREMATORIAL Chester cemetery
22d. LOCATION (City, town, or county) Chestertown, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Narvin V. Williams		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE AUG 28 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial/transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in every case within 24 hours after death.

財政部（2019年版）税目別会計基準（第1回）

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

tems 1&20 Film 233 8-29-58 ans

9159

CERTIFICATE OF DEATH

Reg. Dist. No.

09159

1. PLACE OF DEATH a. COUNTY		Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Queen Anne		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown R. D. 1		17X-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Hosp.				d. STREET ADDRESS Rolf's Warf		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First James	Middle Larry	Last Bonwill	4. DATE OF DEATH	Month Aug	Day 17	Year 1958
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	June 3 1955	9. AGE (In years last birthday) 3 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY infant		11. BIRTHPLACE (State or foreign country) Chestertown, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James Brice Bonwill		14. MOTHER'S MAIDEN NAME Ortha Lee Purdue						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. -----		17. INFORMANT James B. Bonwill		Address Chestertown, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 929.8		Asphyxiation				INTERVAL BETWEEN ONSET AND DEATH 4.0 minutes		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause if lost. (b)		Drowning						
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Child was left unattended near a swimming hole, apparently fell in.						
20c. TIME OF INJURY Hour 2:45 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Water Hole		20f. (City or town) Kingstown (County) Queen Anne (State) Md		
21. I certify that I attended the deceased from _____		1958		to _____		1958, that I last saw the deceased alive on _____		
alive on _____		1958		to _____		1958, and that death occurred at 3:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown		
ACTUAL SIGNATURE Thomas J. Solon				M.D.		DATE SIGNED 8/17/58		
PHYSICIAN'S NAME (Type) Thomas J. Solon						Chestertown, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 19/58		22c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery		22d. LOCATION (City, town, or county) Chestertown, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE AUG 20 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

2018年1月10日星期五 08:00:00

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09160

9160

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY KENT			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown			c. LENGTH OF STAY IN 1b 1 da.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Ann Hospital			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		
3. NAME OF DECEASED (Type or print) Jennie W. Bryden			First	Middle	Last
4. DATE OF DEATH Aug. 17 1958			Month	Day	Year
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 3 1885	9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Baltimore Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James A. Pearman			14. MOTHER'S MAIDEN NAME Laura Joyce		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 220-16-9949 17. INFORMANT Albert Bryden Rock Hall, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 DAY		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. ~			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chestertown	20f. (City or town) (County) Rock Hall, Md. (State)
21. I certify that I attended the deceased from 8/15 , 1958, to 8/17 , 1958, that I last saw the deceased alive on 8/17 , 1958, and that death occurred at 11 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chesapeake Maryland DATE SIGNED 8/17/58					
ACTUAL SIGNATURE Thomas J. Solan			M.D.		
PHYSICIAN'S NAME (Type) Thomas J. Solan			Chestertown, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 20, 1958	22c. NAME OF CEMETERY OR CREMATORIAL Wesley Chapel Cem.	22d. LOCATION (City, town, or county) Rock Hall, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams			ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR Aug 20 '58	24b. REGISTRAR'S SIGNATURE Charles S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached or use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2023 RELEASE UNDER E.O. 14176

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09161

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		b. COUNTY Queen Anne	
c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barclay	
d. NAME OF HOSPITAL (If not in hospital, give street address) Kent & Queen Anne Hosp		d. STREET ADDRESS 17x-2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Lester	Middle Morris	Last Davis Jr
4. DATE OF DEATH	Month August	Day 19	Year 1958
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/17/58
9. AGE (In years last birthday) yrs. 3	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Lester Norris Davis Sr	14. MOTHER'S MAIDEN NAME Blanche Wilson	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.	17. INFORMANT Mother	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congenital debility DUE TO 773.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6 months. Premature baby DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chesapeake	20f. (City or town) Millington (County) Md (State) Maryland
21. I certify that I attended the deceased from Aug 17, 1958 to Aug 18, 1958 , that I last saw the deceased alive on Aug 18, 1958 , and that death occurred at Maryland , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8-19-58			
ACTUAL SIGNATURE Geza Koralewski	M.D.	DATE SIGNED	
PHYSICIAN'S NAME (Type) Geza Koralewski	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		
22b. DATE THEREOF Aug. 20/58	22c. NAME OF CEMETERY OR CREMATORIAL Chesapeake Cem.	22d. LOCATION (City, town, or county) Chesapeake, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams - Chestertown Md.	ADDRESS Chesapeake, Md.	24a. REC'D BY REGISTRAR Arthur S. Frazee	
VS A15 (4) 15M 9/55	DATE AUG 22 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Frazee	

2072321XVV

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09162

CERTIFICATE OF DEATH

Reg. Dist. No.

9170

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md.		b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond		c. LENGTH OF STAY IN 1b adult life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chestertown		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Clarence M. Dorsey	Middle	Last	4. DATE OF DEATH	Month Aug. 21, 1958	Day 19	
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 7, 1889	9. AGE (In years less birthday) 69 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Various	11. BIRTHPLACE (State or foreign country) Kent Co. Md.	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Wesley Dorsey		14. MOTHER'S MAIDEN NAME Eleanor Hance		Address Still Pond, Md.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-20-7109	17. INFORMANT Reba Dorsey	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 493X pneumonia INTERVAL BETWEEN ONSET AND DEATH 1 day arteriosclerosis unknown				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour p. m.		Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Worton, Md.	(County) Md.	(State) Md.
21. I certify that I attended the deceased from <u>Aug 20, 1958</u> to <u>Aug 21, 1958</u> that I last saw the deceased alive on <u>Aug 21, 1958</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Florence D. Joyce</u> M.D. ADDRESS (Street, city or town, state) Worton, Md. DATE SIGNED 8/22/58								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/24/24	22c. NAME OF CEMETERY OR CREMATORIUM Coleman's Cem.		22d. LOCATION (City, town, or county) Worton RFD			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hannah Walker</u>		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE Aug 26 1958		24b. REGISTRAR'S SIGNATURE Dorothy P. Hause		

STATE OF OKLAHOMA - DIVISION OF HIGHWAYS
CERTIFICATE OF DESIGN

Yulee Stewart

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09163

9171

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville		c. LENGTH OF STAY IN 1b 6 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville	
3. NAME OF DECEASED (Type or print) Wilks H. Douglas		d. STREET ADDRESS	
5. SEX male white		6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH June 7, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heating Eng.		9. AGE (In years last birthday) yrs 71	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wisconsin	
13. FATHER'S NAME Malcolm Douglas		12. CITIZEN OF WHAT COUNTRY USA	
14. MOTHER'S MAIDEN NAME Leitia Jane Grinnell		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 162-03-7149		17. INFORMANT Mrs. Elaine W. Douglas	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		acute Cardiac insufficiency INTERVAL BETWEEN ONSET AND DEATH 1 week	
DUE TO rheumatic fever		childless	
DUE TO ④ Rheumatic valvular disease		childless	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic cerebro vascular disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 1954, to <u>Aug 22</u> , 1958, that I last saw the deceased alive on <u>Aug 22</u> , 1958, and that death occurred at <u>9:30</u> A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Florence D. Joyce, M.D.</i>		ADDRESS (Street, city or town, state) Worton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 25, 1958	
22c. NAME OF CEMETERY OR CREMATORIAL Chester Cem.		22d. LOCATION (City, town, or county) Chestertown, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Willis Wells</i>		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR AUG 26 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached or use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

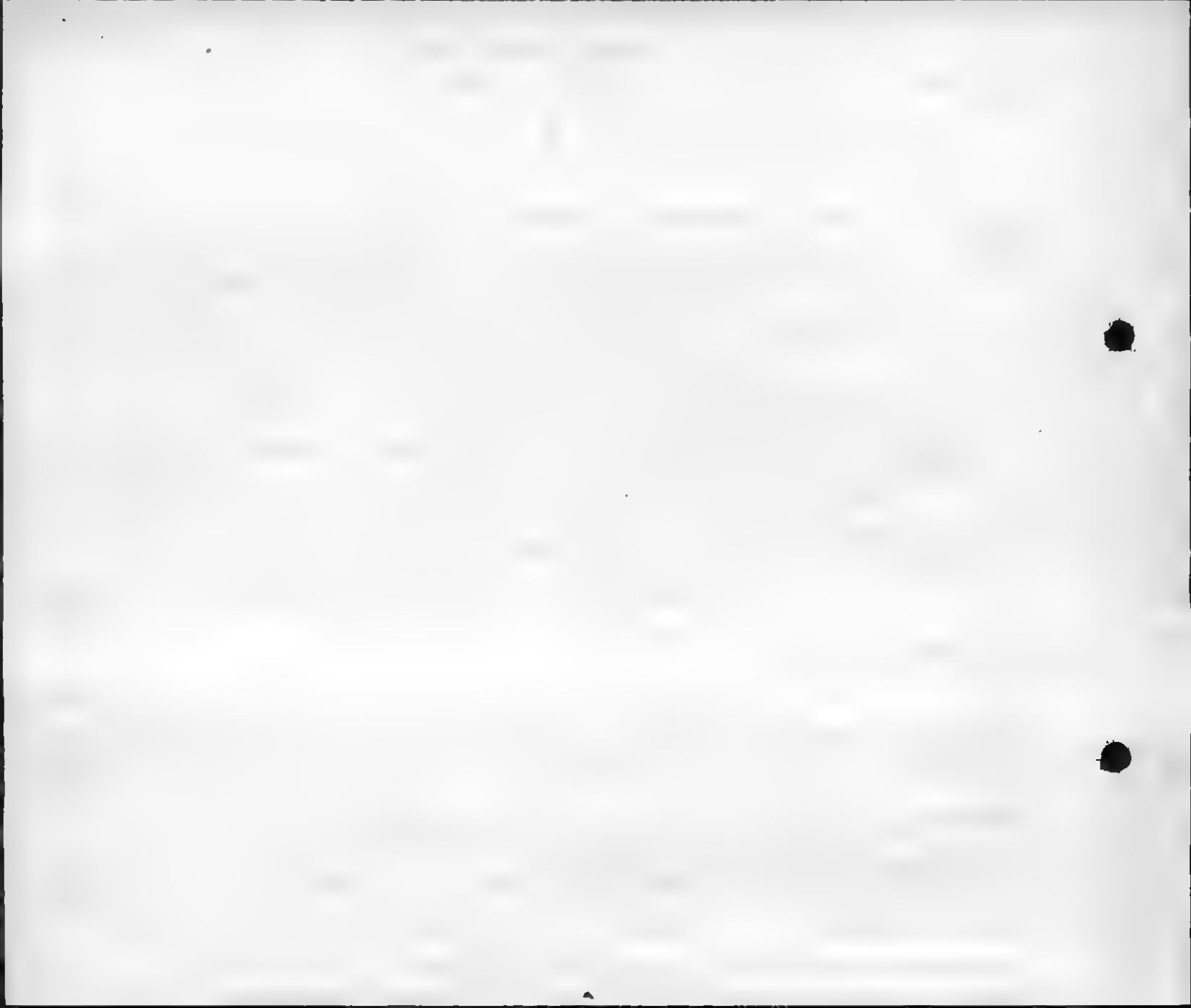
9162

CERTIFICATE OF DEATH

09164

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY KENT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD		b. COUNTY KENT		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN		c. LENGTH OF STAY IN 1b 2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN		d. STREET ADDRESS 114 WATER ST.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENT + QUEEN ANNE'S				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) NAOMI		First W.	Middle KEITH	Last GRIFFITH	4. DATE OF DEATH AUG 15 1958.	Month AUG	Day 15	Year 1958.
5. SEX Female	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/12/1898	9. AGE (In years last birthday) 60 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. MIN
10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME DANIEL P. KEITH		14. MOTHER'S MAIDEN NAME LILLIAN PRICE						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 207-20-3076		17. INFORMANT HOSPITAL CHART		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver Failure						INTERVAL BETWEEN ONSET AND DEATH 5 min		
Conditions, if any, which give rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) Cirrhosis of the Liver				2 years.		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OPERATIVE ANESTHESIA						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 8.14 , 19 58 , to 8.15 , 19 58 , that I last saw the deceased alive on 8.15 , 19 58 , and that death occurred at 10 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>A. T. Keefe, Jr. M.D.</i>				ADDRESS (Street, city or town, state) Chestertown, Md.		DATE SIGNED 8.15.58		
PHYSICIAN'S NAME (Type) A. T. KEEFE, JR. M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/18/58		22c. NAME OF CEMETERY OR CREMATORIUM FOREST CEM.		22d. LOCATION (City, town, or county) MIDDLETON (State) DEL.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Glennie Wells</i>		ADDRESS Chestertown		24a. REC'D BY REGISTRAR JULY 18 '58		24b. REGISTRAR'S SIGNATURE <i>John L. King</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

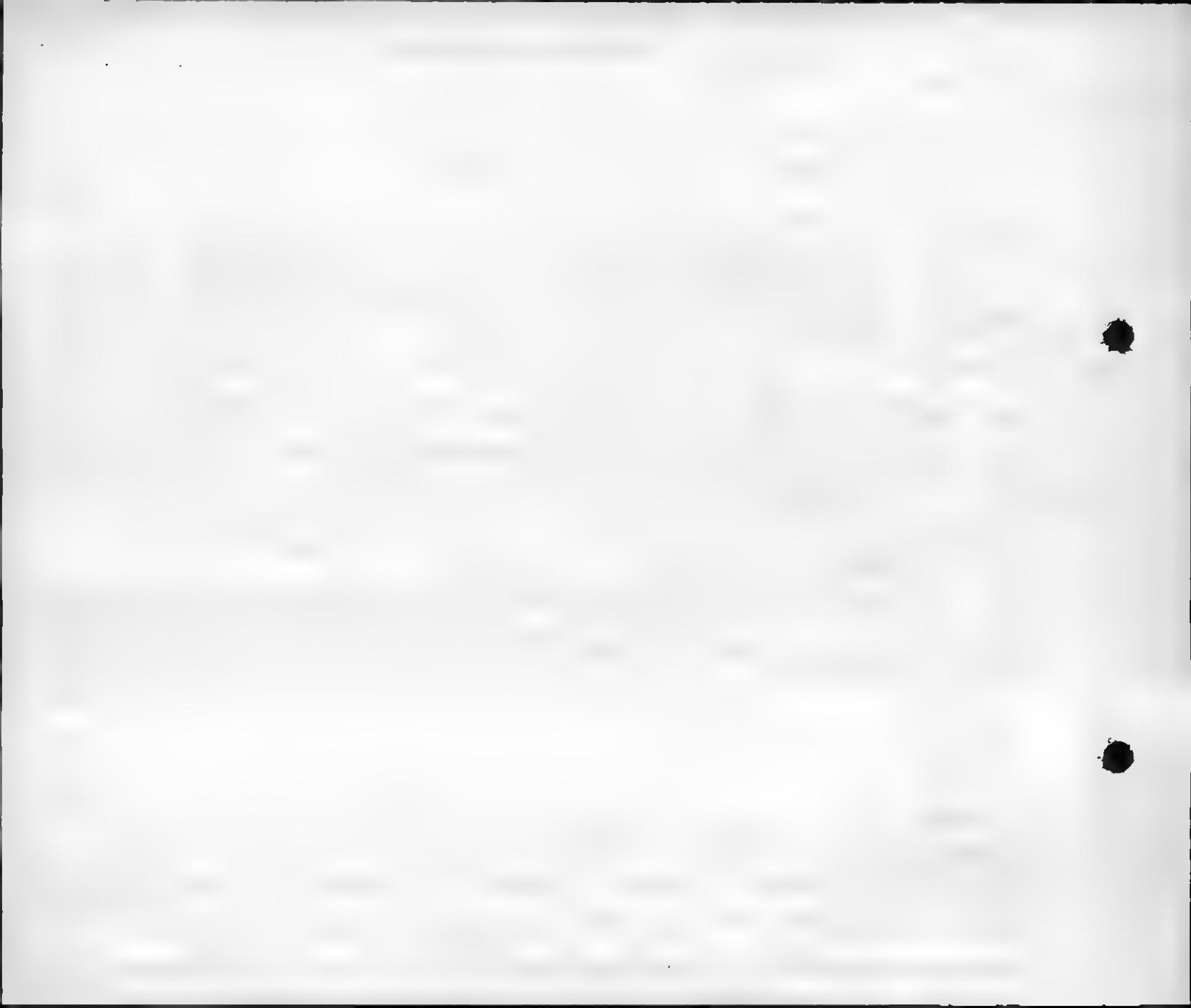
09165

9163

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY KENT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERVILLE		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First VIRGINIA	Middle	Last HAWKINS
4. DATE OF DEATH	Month AUG.	Day 7	Year 1958
5. SEX F.	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 25, 1958
9. AGE (In years lost birthday) yrs. 6	10. IF UNDER 1 YEAR 6	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
13a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) BABY	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) MD.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME JAMES HAWKINS	14. MOTHER'S MAIDEN NAME CLAUDETTE JOHNSON	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 5710	16. SOCIAL SECURITY NO NONE	17. INFORMANT Mrs. CLAUDETTE JOHNSON, Millington, Md.	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) Acute Enteritis
			INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5710 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diet DUE TO (c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Rock Hall
(County)	(State)		
21. I certify that I attended the deceased from Aug. 5, 1958 to Aug. 6, 1958 that I last saw the deceased alive on Aug. 5, 1958 , and that death occurred at 12 PM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Rock Hall, Md.			DATE SIGNED
ACTUAL SIGNATURE E. Kester			
PHYSICIAN'S NAME (Type) E. KESTER			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Aug. 9, 1958	22c. NAME OF CEMETERY OR CREMATORIAL CHESTERVILLE CEM.	22d. LOCATION (City, town, or county) CHESTERVILLE MD.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Bellows, Millington, Md.	ADDRESS 24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE W. L. Smith	
VS A15 (4) 15M 9/55	DATE AUG 11 '58		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09166

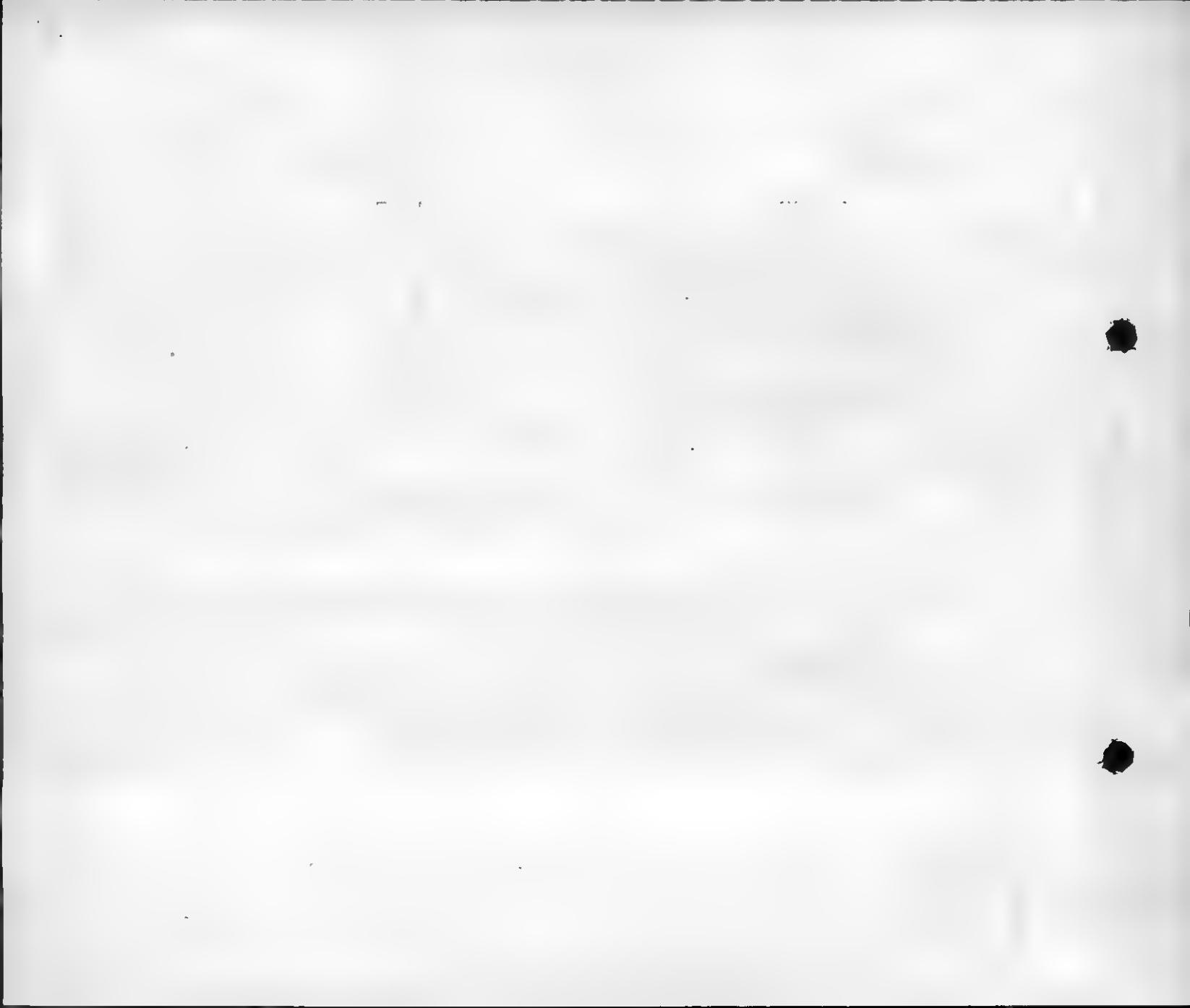
9172

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Ada	Middle Hepbron	Last Hill	4. DATE OF DEATH August 8	Month August	Day 8	Year 1958
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1877	9. AGE (In years last birthday) 81	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME William Thomas Hepbron		14. MOTHER'S MAIDEN NAME Frances Webb						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Raymond Hill		Address Kennedyville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Cerebral Thrombosis				INTERVAL BETWEEN ONSET AND DEATH 3 mos.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility		Cerebral Arteriosclerosis				years.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>June</u> , 1958, to <u>Aug 8</u> , 1958, that I last saw the deceased alive on <u>Aug 8</u> , 1958, and that death occurred at <u>6 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) Wallace Obenshain M. D. Cecilton, Md.						DATE SIGNED 9 Aug 58		
ACTUAL SIGNATURE Wallace Obenshain M. D.								
PHYSICIAN'S NAME (Type) Wallace Obenshain M. D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/12/58		22c. NAME OF CEMETERY OR CREMATORIUM Still Pond Cemetery		
22d. LOCATION (City, town, or county) Still Pond, Md.						(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy		ADDRESS Still Pond, Md.		24a. REC'D BY REGISTRAR DATE AUG 11 58		24b. REGISTRAR'S SIGNATURE Av. Seach		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician a copy of it should be given to the funeral director.
 page 3 should be detached or use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9164

CERTIFICATE OF DEATH

09167

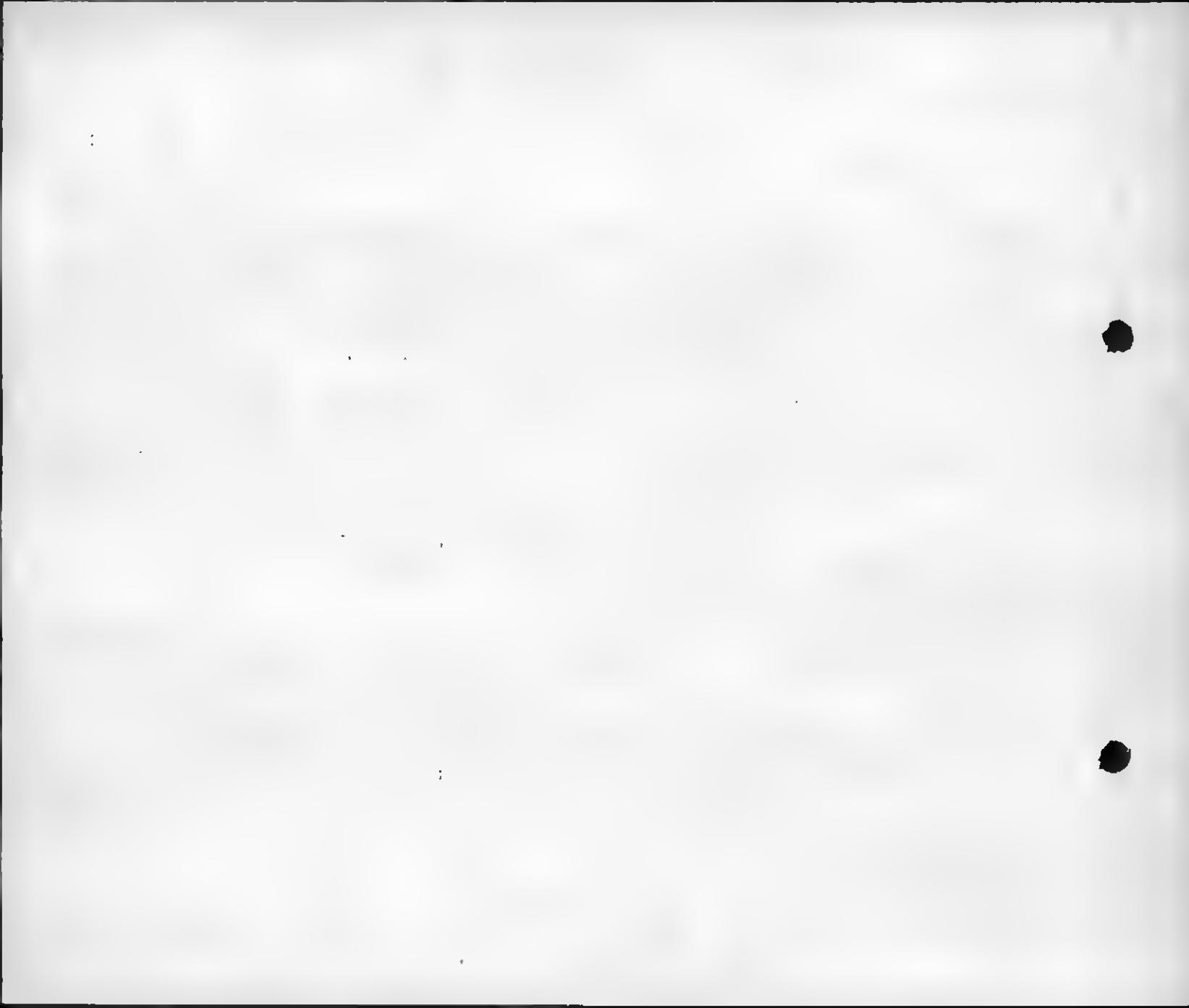
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hosp. (1 day)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Charles		First	Middle	Last	4. DATE OF DEATH Aug. 29, 1958	Month Aug.	Day 29	Year 1958
S. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH JUNE 23 1886	9. AGE (In years last birthday) 72 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer around the water		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kent CO. Md.		12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME Charles T. Johnson		14. MOTHER'S MAIDEN NAME Mary E. Phillips						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tax. no. or unknown) no		16. SOCIAL SECURITY NO dont know		17. INFORMANT Dolly Cunningham		Address Newark Dela.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Pulmonary congestion, & probable bronchopneumonia (c)						INTERVAL BETWEEN ONSET AND DEATH long time		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 471X						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Doy	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Chestertown	(County)	(State)
21. I certify that I attended the deceased from olive on 8/29/58		August 28, 1958		to Aug 29, 1958		that I last saw the deceased at 1:30P M, from the causes and on the date stated above.		
ACTUAL SIGNATURE <i>Robert V. Farr</i>						ADDRESS (Street, city or town, state) Chestertown, Md.		
PHYSICIAN'S NAME (Type) Robert V. Farr						DATE SIGNED 8/30/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF AUG. 31	22c. NAME OF CEMETERY OR CREMATORIUM Chester Cemetery		22d. LOCATION (City, town, or county) Chestertown, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Willis Wells</i>		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE SEP 2 '58		24b. REGISTRAR'S SIGNATURE <i>Arnold S. Francis</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A certificate has been signed by the attending physician and completely filled in by the funeral director; page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial.

VS ATS (4)
1SM 10/57



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Item 3 should be used as a burial-transit permit. File Pages 1, 2, and 2 with the State Board of Health, or its designee, agent, prior to burial, cremation, or removal, and in my event within 72 hours after death.

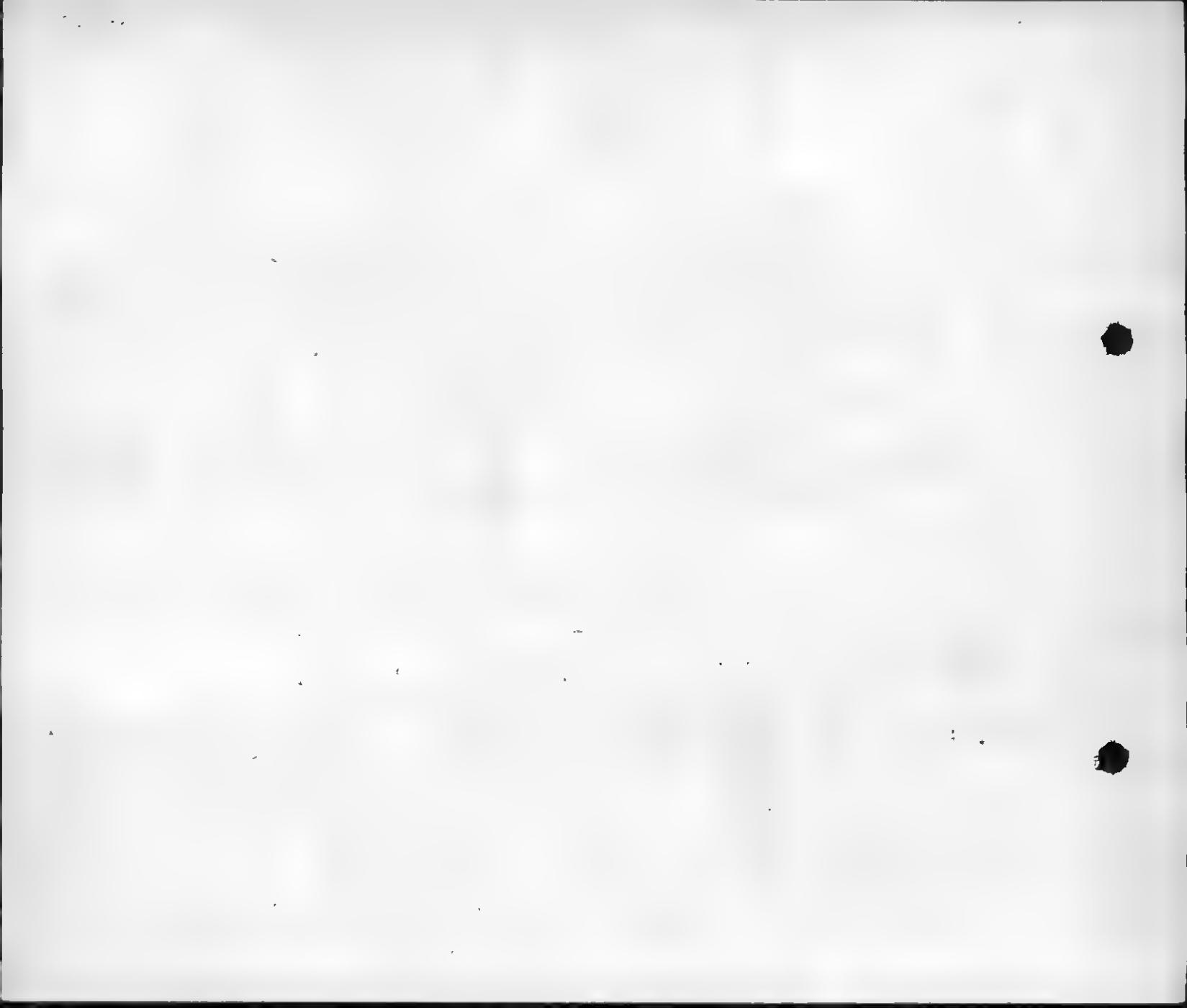
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9173 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09168

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Kent		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Kent	
Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
RFD Sandy Bottom		RFD Sandy Bottom	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
John A. Johnson		lost	4. DATE OF DEATH
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
Male		colored	8. DATE OF BIRTH
9. AGE (In years lost to nearest)		9. IF UNDER 1 YEAR	
48 yrs		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Laborer - Bricklayer's helper		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Arthur Johnson		Amanda Wickes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown)		16. SOCIAL SECURITY NO	
no		17. INFORMANT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Yes	
DUE TO		EMMA DOMAX	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Address	
(b)		Chestertown, Md.	
(c)			
19. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
History of acute alcoholism - one or two hours before death		few minutes	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
CAUSE OF DEATH: Probably set mattress afire smoking in bed.		Found dead in burning house, intoxicated shortly before	
20c. TIME OF INJURY Month, Day, Year Hour		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
11:00 P.M. 8/1 1958		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		home	
		(City or town) (County) (State)	
		Chestertown Kent Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE		8/2/58	
EXAMINER'S NAME (Type)		MD CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
Robert W. Farr		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION OR REMOVAL (Specify)		22c. NAME OF CEMETERY OR CREMATORIAL Sandy Bottom Cem. near Chestertown, Md.	
Burial		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REGISTRY REGISTRAR ADDRESS	
Genneth Wally		AUG 4 Chestertown, Md.	
		24b. REGISTRAR'S SIGNATURE	
		John Edwards	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, **Page 3 should be detached or use as the burial/transit permit.** Then please remove ~~certified copies~~ **Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.**

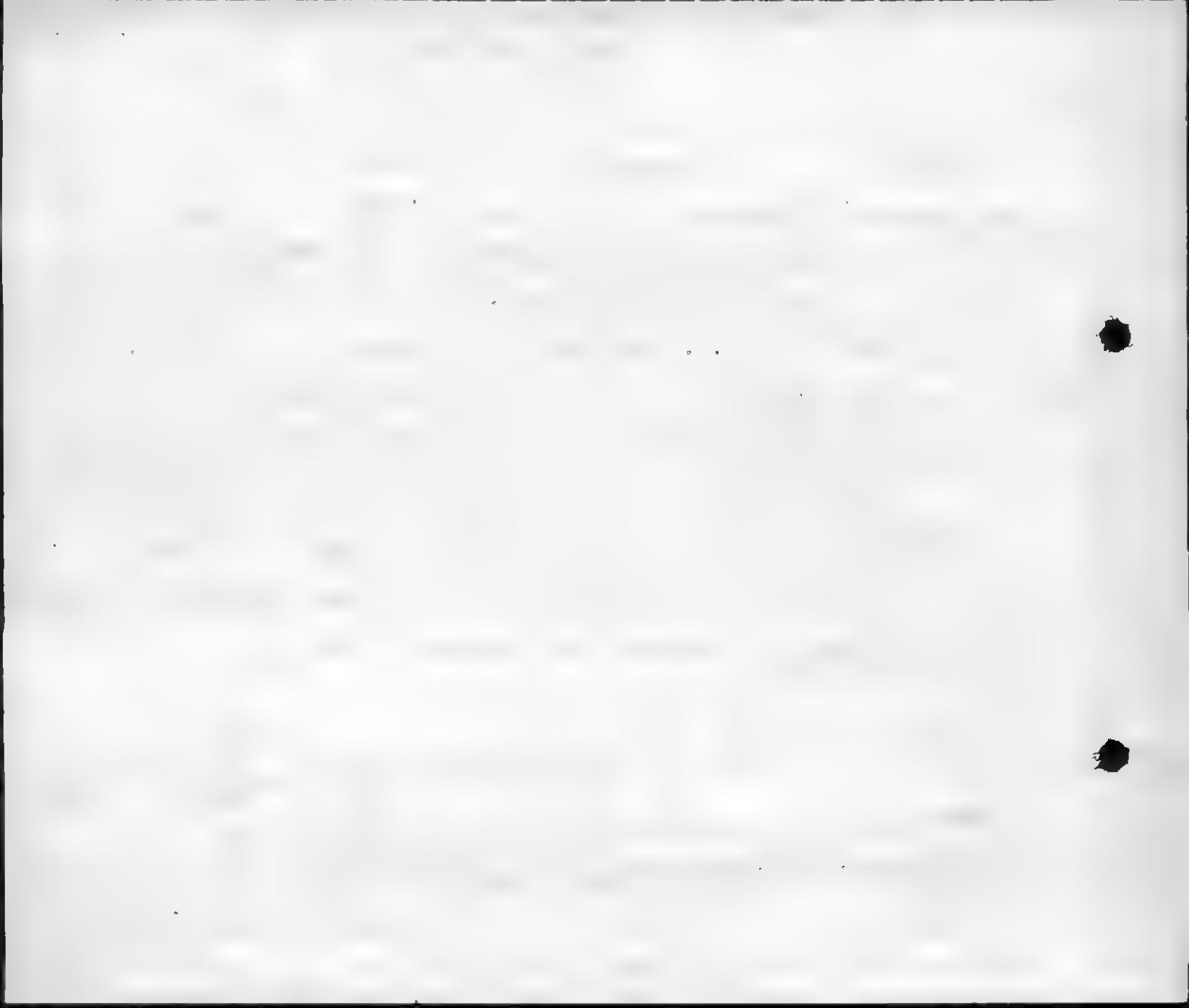
09169

9174

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH ■ COUNTY Kent			MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Betterton		c. LENGTH OF STAY IN lb Lifetime		a. STATE Maryland		b. COUNTY Kent		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Howard	Middle	Last Leigh	4. DATE OF DEATH August	Month	Day 14	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1875		9. AGE (In years (to birthday) 82 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Commander			10b. KIND OF BUSINESS OR INDUSTRY U.S. Coast Guard		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John Leigh			14. MOTHER'S MAIDEN NAME (1st unk.) Turner			Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes			16. SOCIAL SECURITY NO. None		17. INFORMANT John S. Leigh Judie Lane, Ambler, Pa.		INTERVAL BETWEEN ONSET AND DEATH days	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			DUE TO (b) <i>Cardiac condition</i> DUE TO (c) <i>Cardiac condition</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Chestertown	(County)	(State)		
21. I certify that I attended the deceased from <i>Sept. 14, 1958</i> to <i>Aug. 14, 1958</i> , that I last saw the deceased alive on <i>Sept. 14, 1958</i> , and that death occurred at <i>11 A.M.</i> from the causes and on the date stated above.								
ADDRESS (Street, city or town, state)								
ACTUAL SIGNATURE <i>A. C. Dick, M.D.</i>								
DATE SIGNED <i>Sept. 14, 1958</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/17/58		22c. NAME OF CEMETERY OR CREMATORIUM Still Pond Cemetery		22d. LOCATION (City, town, or county) Still Pond Md.		
(State)								
23. FUNERAL DIRECTOR'S SIGNATURE <i>Victor N. Kennedy</i>			ADDRESS Still Pond, Md.		24a. REC'D BY REGISTRAR AUG 19 '58		24b. REGISTRAR'S SIGNATURE <i>Victor N. Kennedy</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9165

CERTIFICATE OF DEATH

Reg. Dist. No.

09170

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit Permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		d. STREET ADDRESS 341 Calvert St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent and Queen Anne				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Lillie or Tillie		First	Middle	Last	4. DATE OF DEATH Aug 3, 1958	Month	Day	Year
5. SEX Female		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 27, 1885	9. AGE (in years last birthday) 73 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & laborer at cannery		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S. A.		
13. FATHER'S NAME Amos Johnson		14. MOTHER'S MAIDEN NAME Fannie Washington						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO 220-03-4633		17. INFORMANT Wm. E. Butler - Chestertown, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Hemina				INTERVAL BETWEEN ONSET AND DEATH 8 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) arterio-sclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Worton, Md.		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>June</u> , 19 <u>58</u> , to <u>August</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>August 7, 1958</u> , and that death occurred at <u>Worton, Md.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Worton, Md.		DATE SIGNED 8/3/58		
ACTUAL SIGNATURE Florence D. Joyce								
PHYSICIAN'S NAME (Type) Florence D. Joyce				Worton, Md. RFD				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/6/58		22c. NAME OF CEMETERY OR CREMATORIAL Janes Cem.		22d. LOCATION (City, town, or county) Chestertown, Md		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Wallay		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE AUG 6 '58		24b. REGISTRAR'S SIGNATURE A. Lewis!		



9175

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Kent</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Md.</i>	b. COUNTY <i>Kent</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rock Hall</i>	c. LENGTH OF STAY IN 1b <i>Lifetime</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rock Hall</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <i>GEORGE</i>	Middle <i>PRICE</i>	Last <i>ORR</i>	4. DATE OF DEATH Month <i>Aug</i>	Day <i>2</i>	Year <i>1958</i>				
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 9, 1874</i>		9. AGE (in years last birthday) <i>84</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>0</i>	Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during not of working life, even if retired) <i>Carpenter</i>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Alexander Orr</i>			14. MOTHER'S MAIDEN NAME <i>Frances Schreiber</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <i>212-14-45583</i>			17. INFORMANT <i>Frances Taylor Chastain</i>	Address <i>1125 Chestertown Rd</i>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		
DUE TO <i>Pneumonia</i>		
{ (b)		
DUE TO <i></i>		
{ (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour <i>o. 51.</i> p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from *Aug 1, 1958*, to *Aug 2, 1958*, that I last saw the deceased alive on *Aug 1, 1958*, and that death occurred at *44 M.* from the causes and on the date stated above.

ACTUAL
SIGNATURE *William M. Gatewood, M.D.* DATE SIGNED *Aug 2, 1958*
PHYSICIAN'S
NAME (Type) *William M. Gatewood, M.D.*

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>Aug 5, 1958</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Worley Chapel</i>	22d. LOCATION (City, town, or county) <i>Rock Hall, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar L. Lane</i>	ADDRESS <i>Church Hill Rd.</i>	24a. RECEIVED BY REGISTRAR <i>AUG 6 1958</i>	24b. REGISTRAR'S SIGNATURE <i>John W. Johnson</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician or by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 9176 CERTIFICATE OF DEATH

Reg. Dist. No. 09172

1. PLACE OF DEATH a. COUNTY Kent		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		c. LENGTH OF STAY IN 1b Life		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Helen		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> June 30, 1905	9. AGE (In years lost/birthday) 53 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Cannery		11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Isaac Hynson		14. MOTHER'S MAIDEN NAME Martha		15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown no		16. SOCIAL SECURITY NO 220-03-8170		17. INFORMANT Doris Johnson Rock Hall, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH Half hour			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b)		Hypertension.					
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Doy	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Rock Hall	(County)	(State)	
21. I certify that I attended the deceased from <u>8/10/</u> 1958 to <u>8/10/</u> 1958, that I last saw the deceased alive on <u>8/10/</u> 1958, and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <i>Eugene Kester</i>								Aug. 11, 1958	
PHYSICIAN'S NAME (Type) Eugene Kester						Rock Hall, Md.			
22a. BURIAL, CREMATION, BURIAL (Specify) Burial		22b. DATE THEREOF 8/13/58		22c. NAME OF CEMETERY OR CREMATORIUM Sharptown		22d. LOCATION (City, town, or county) near Rock Hall, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth Wally</i>		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE ARTHUR S. KRAUSE			
				AUG 13 '58					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09173

9166

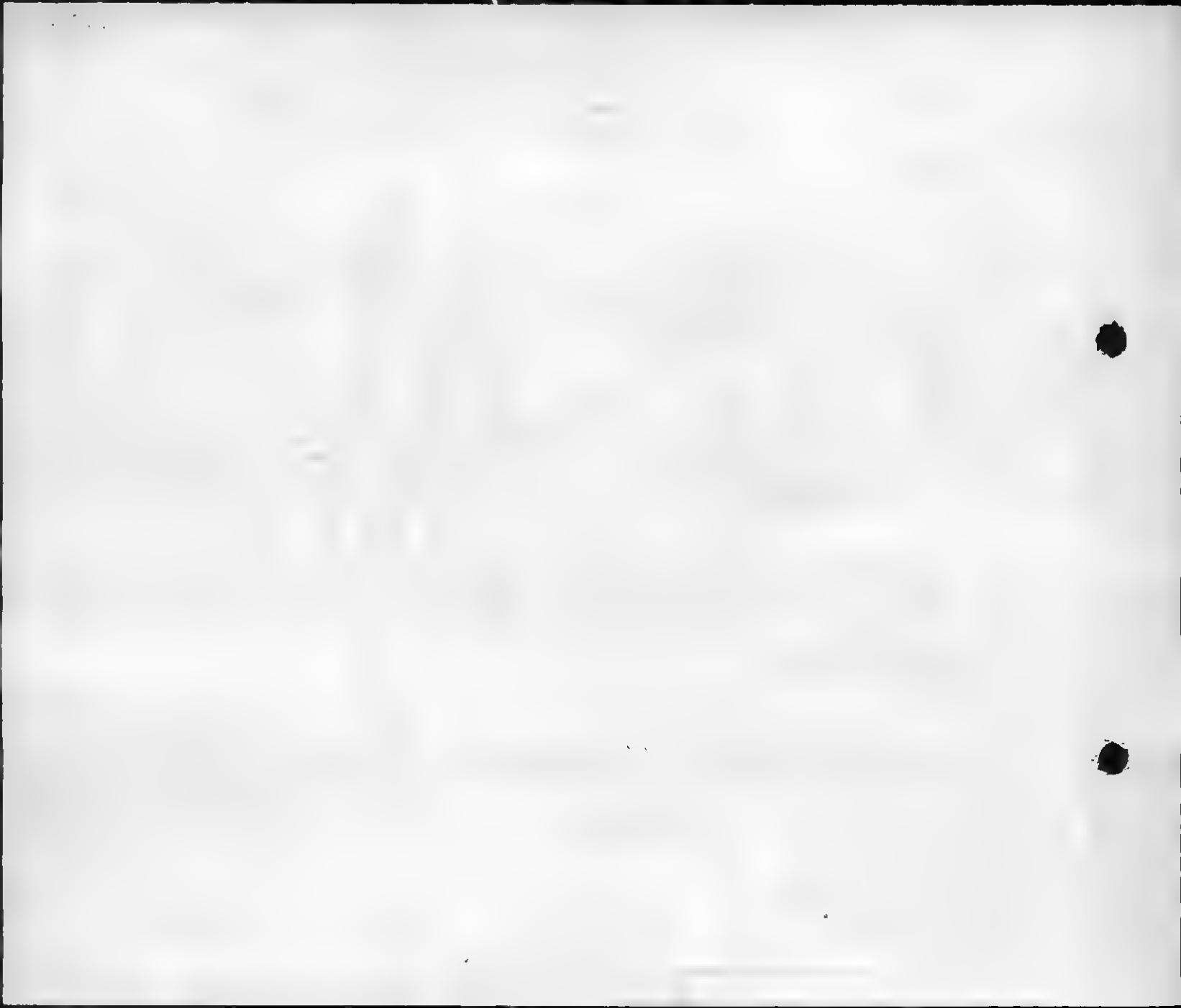
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY KENT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY KENT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b very short		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rock Hall		d. STREET ADDRESS RED Edesville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENT & Queen Anne's Hosp				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Edward		First	Middle	Lost	4. DATE OF DEATH ROCHESTER	Month AUGUST	Day 14	Year 1958	
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ?	9. AGE (In years lost birthday) 90-95 yrs.	IF UNDER 1 YEAR Months 90	IF UNDER 24 HRS. Days 95	Hours 00	Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Cecil		12. CITIZEN OF WHAT COUNTRY/ U.S.			
13. FATHER'S NAME John Rochester				14. MOTHER'S MAIDEN NAME UNKNOWN					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Ethel L. Hicks, Rock Hall, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		CORONARY Occlusion		GENERALIZED Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Marked Dehydration						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None							
20c. TIME OF INJURY Month, Day, Year Hour o. p. n. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 111 High St Chestertown, Md.		20f. (City or town) Rock Hall, Md.		(County) Cecil Co.	(State) Md.
21. I certify that I attended the deceased from 14 July, 1958 to 8 August, 1958 , that I last saw the deceased alive on 8 August, 1958 , and that death occurred at 7:45 P.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE Harry Paul Ross				ADDRESS (Street, city or town, state) 111 High St Chestertown, Md.		DATE SIGNED 14 Aug 58			
PHYSICIAN'S NAME (Type) HARRY PAUL ROSS									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 17, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Sharptown Cem.		22d. LOCATION (City, town, or county) near - Rock Hall, Md.		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John S. Kline		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR Arthur S. Kline		24b. REGISTRAR'S SIGNATURE Arthur S. Kline			
				DATE AUG 18 '58					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09174

9167

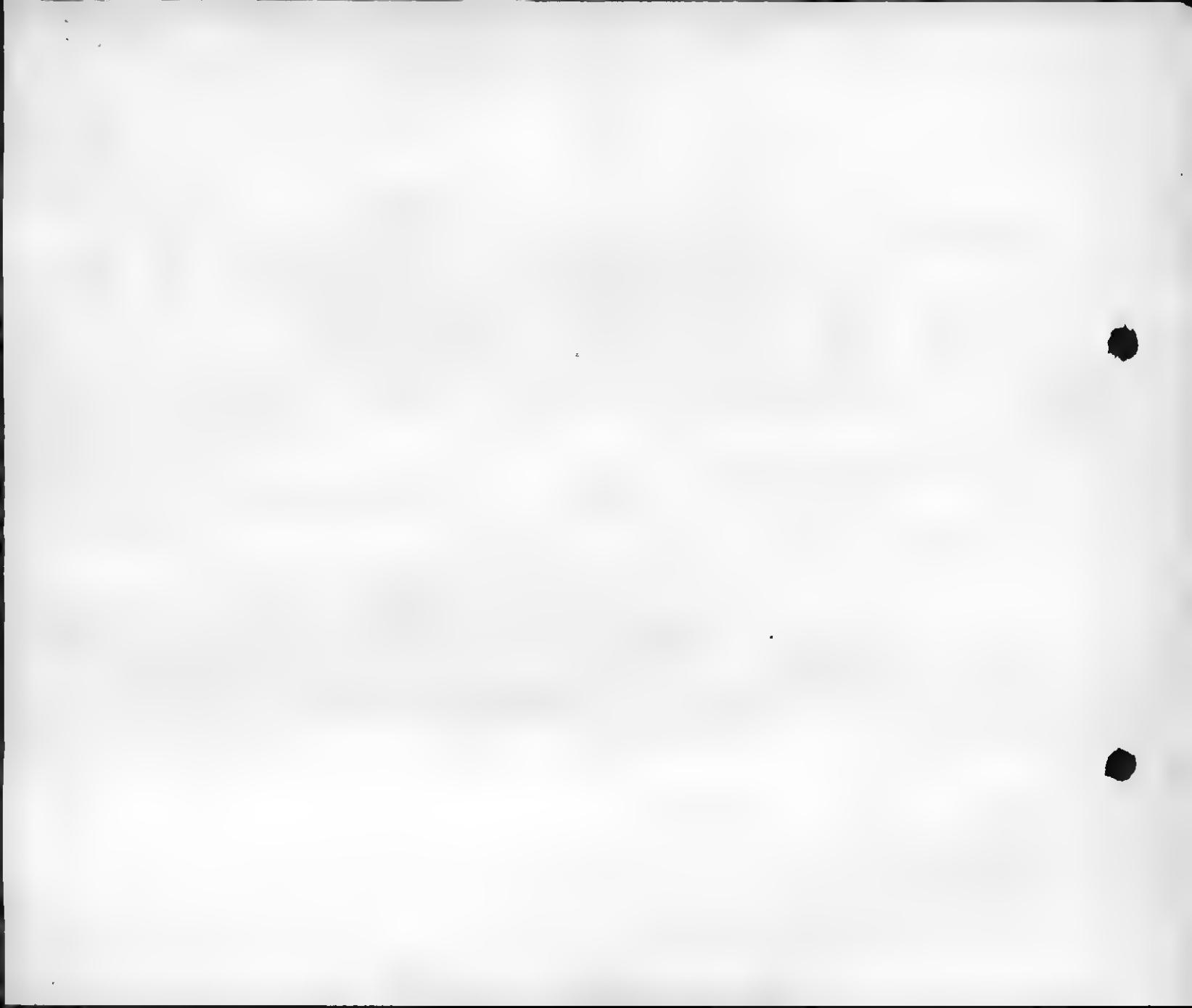
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Ent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. LENGTH OF STAY IN 1b <u>Most of life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Ave.</u>		d. STREET ADDRESS <u>Washington, Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary Augusta Selby</u>		First	Middle
4. DATE OF DEATH <u>Aug. 20, 1958</u>		Last	Month Day Year <u>Aug. 20, 1958</u>
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH <u>May 12, 1872</u>		9. AGE (In years last birthday) <u>86</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife & labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kent Mfg. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Kent Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Romayne Strong</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Wickes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>YES</u>	
17. INFORMANT <u>Owen Selby</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Congestive Heart Failure - Chronic</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Arteriosclerosis</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Chestertown</u> (County) <u>Md.</u> (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>11/8/56</u> to <u>8/20/58</u> , that I last saw the deceased alive on <u>8/20/58</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u> DATE SIGNED <u>8/21/58</u>			
ACTUAL SIGNATURE <u>Thomas J. Solon</u>		PHYSICIAN'S NAME (Type) <u>Thomas J. Solon</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/23/58</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>St. Paul Cem.</u>		22d. LOCATION (City, town, or county) <u>near - Chestertown, Md.</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>		24a. REC'D BY REGISTRAR DATE <u>Aug 25 '58</u>	
ADDRESS <u>Chestertown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Albert S. Krause</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached or use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Item 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1 Item 20b Med. Exam Office 10-17-70 AMB MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9168 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09175

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY	KENT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	MARYLAND		a. STATE DELAWARE b. COUNTY KENT
CHESTERTOWN		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
KENT & Q.A. HOSPITAL		DOVER 46 X-3	

3. NAME OF -DECEASED (Type or print)	First JOHN	Middle VAN	Last WILLIS	4. DATE OF DEATH
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 18-1929	9. AGE (In years last birthday) 29 yrs.
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	29	10. IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CONTRACTOR	BUILDING	MARYLAND	USA

13. FATHER'S NAME JOHN VAN WILLIS JR.	14. MOTHER'S MAIDEN NAME ISABELLE BINEBRINK		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. 215-26-5793	17. INFORMANT JOHN VAN WILLIS	Address CHURCH HILL
Yes	KOREAN		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 9776X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot himself through head with rifle

20c. TIME OF INJURY Month, Day, Year Hour 8:30 a. m. 8/31-1958 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State road	20f. (City or town) near Church Hill-24 to 1/2	(County) 2A	(State) Md.
----------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------	---------------------------------------------------	-------------	-------------

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>

ACTUAL SIGNATURE W. Henry Fisher	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 9/3-58
EXAMINER'S NAME (Type) W. Henry Fisher	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	

22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 3	22c. NAME OF CEMETERY OR CREMATORIAL Lakeside	22d. LOCATION (City, town, or county) Dover
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Fane Church Hill		ADDRESS	24a. REC'D. BY REGISTRAR SEP 5 1958 DATE
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

97 DOCUMENTATION OF THE 70 TRUCKS WHICH WERE CAPTURED
BY THE 40th ENGINEER REGIMENT IN THE ZAGORJE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. File pages 1 and 2 with the State Board of Health, and page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, and page 3 should be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, and page 3 should be retained for your files.

or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
SM 2/37

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9177

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film 233 9-2-58 et

09176

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> <u>Kent</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Golts</u> <u>Golts</u> c. LENGTH OF STAY IN 1b <u>13 months</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Golts (Rural)</u> d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Willie Franklin Young</u>		First <u>Willie</u> Middle <u>Franklin</u> Last <u>Young</u>	4. DATE OF DEATH <u>August 19</u> Month <u>August</u> Day <u>19</u> Year <u>1958</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Jan 12 1894</u> 9. AGE (In years last birthday) <u>64</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>Msa</u>			
13. FATHER'S NAME <u>George Young</u>		14. MOTHER'S MAIDEN NAME <u>Sinton Hobson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>795.3</u>		16. SOCIAL SECURITY NO. <u>221 12 5433</u>	17. INFORMANT <u>George R Young</u> Address <u>360 Edmond St., Baltimore, Md.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Unknown causes but probably natural ones</u> DUE TO <u>795.3</u> INTERVAL BETWEEN ONSET AND DEATH <u>?</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Deceased, apparently well, had gone out to get cows on the farm</u> DUE TO <u>where he worked up to the barn. When he did not return, after</u> (c) <u>a search, he was found dead out in the field, about 8:30 AM</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>Robert W. Farr</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>August 19, 1958</u>
EXAMINER'S NAME (Type) <u>Robert W. Farr, M.D.</u>	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8/23/58</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Mt. Pleasant Cem.</u>	22d. LOCATION (City, town, or county) <u>Golf, Kent Co. Md.</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows, Millington, Md.</u>	ADDRESS	24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>
DATE <u>AUG 26 '58</u>			

RECORDED—RECORDED TO TWENTY-THREE YEARS AND ONE MONTH
TUESDAY NOVEMBER TWENTY-THREE AT 10:20 AM

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100
101
102
103
104
105
106
107
108
109
110
111
112
113
114
115
116
117
118
119
120
121
122
123
124
125
126
127
128
129
130
131
132
133
134
135
136
137
138
139
140
141
142
143
144
145
146
147
148
149
150
151
152
153
154
155
156
157
158
159
160
161
162
163
164
165
166
167
168
169
170
171
172
173
174
175
176
177
178
179
180
181
182
183
184
185
186
187
188
189
190
191
192
193
194
195
196
197
198
199
200
201
202
203
204
205
206
207
208
209
210
211
212
213
214
215
216
217
218
219
220
221
222
223
224
225
226
227
228
229
230
231
232
233
234
235
236
237
238
239
240
241
242
243
244
245
246
247
248
249
250
251
252
253
254
255
256
257
258
259
259
260
261
262
263
264
265
266
267
268
269
270
271
272
273
274
275
276
277
278
279
280
281
282
283
284
285
286
287
288
289
289
290
291
292
293
294
295
296
297
298
299
299
300
301
302
303
304
305
306
307
308
309
309
310
311
312
313
314
315
316
317
318
319
319
320
321
322
323
324
325
326
327
328
329
329
330
331
332
333
334
335
336
337
338
339
339
340
341
342
343
344
345
346
347
348
349
349
350
351
352
353
354
355
356
357
358
359
359
360
361
362
363
364
365
366
367
368
369
369
370
371
372
373
374
375
376
377
378
379
379
380
381
382
383
384
385
386
387
388
389
389
390
391
392
393
394
395
396
397
398
399
399
400
401
402
403
404
405
406
407
408
409
409
410
411
412
413
414
415
416
417
418
419
419
420
421
422
423
424
425
426
427
428
429
429
430
431
432
433
434
435
436
437
438
439
439
440
441
442
443
444
445
446
447
448
449
449
450
451
452
453
454
455
456
457
458
459
459
460
461
462
463
464
465
466
467
468
469
469
470
471
472
473
474
475
476
477
478
479
479
480
481
482
483
484
485
486
487
488
489
489
490
491
492
493
494
495
496
497
498
499
499
500
501
502
503
504
505
506
507
508
509
509
510
511
512
513
514
515
516
517
518
519
519
520
521
522
523
524
525
526
527
528
529
529
530
531
532
533
534
535
536
537
538
539
539
540
541
542
543
544
545
546
547
548
549
549
550
551
552
553
554
555
556
557
558
559
559
560
561
562
563
564
565
566
567
568
569
569
570
571
572
573
574
575
576
577
578
579
579
580
581
582
583
584
585
586
587
588
589
589
590
591
592
593
594
595
596
597
598
599
599
600
601
602
603
604
605
606
607
608
609
609
610
611
612
613
614
615
616
617
618
619
619
620
621
622
623
624
625
626
627
628
629
629
630
631
632
633
634
635
636
637
638
639
639
640
641
642
643
644
645
646
647
648
649
649
650
651
652
653
654
655
656
657
658
659
659
660
661
662
663
664
665
666
667
668
669
669
670
671
672
673
674
675
676
677
678
679
679
680
681
682
683
684
685
686
687
688
689
689
690
691
692
693
694
695
696
697
698
699
699
700
701
702
703
704
705
706
707
708
709
709
710
711
712
713
714
715
716
717
718
719
719
720
721
722
723
724
725
726
727
728
729
729
730
731
732
733
734
735
736
737
738
739
739
740
741
742
743
744
745
746
747
748
749
749
750
751
752
753
754
755
756
757
758
759
759
760
761
762
763
764
765
766
767
768
769
769
770
771
772
773
774
775
776
777
778
779
779
780
781
782
783
784
785
786
787
788
789
789
790
791
792
793
794
795
796
797
798
799
799
800
801
802
803
804
805
806
807
808
809
809
810
811
812
813
814
815
816
817
818
819
819
820
821
822
823
824
825
826
827
828
829
829
830
831
832
833
834
835
836
837
838
839
839
840
841
842
843
844
845
846
847
848
849
849
850
851
852
853
854
855
856
857
858
859
859
860
861
862
863
864
865
866
867
868
869
869
870
871
872
873
874
875
876
877
878
879
879
880
881
882
883
884
885
886
887
888
889
889
890
891
892
893
894
895
896
897
898
899
899
900
901
902
903
904
905
906
907
908
909
909
910
911
912
913
914
915
916
917
918
919
919
920
921
922
923
924
925
926
927
928
929
929
930
931
932
933
934
935
936
937
938
939
939
940
941
942
943
944
945
946
947
948
949
949
950
951
952
953
954
955
956
957
958
959
959
960
961
962
963
964
965
966
967
968
969
969
970
971
972
973
974
975
976
977
978
979
979
980
981
982
983
984
985
986
987
988
989
989
990
991
992
993
994
995
996
997
998
999
1000